

Michael J. Abramsky, Ph.D.

DIPLOMATE AMERICAN BOARD OF PROFESSIONAL PSYCHOLOGY

Ryan Fishman. 4-30-21 Intake:

DOB: [REDACTED]

Mr. Fishman was referred by an x-patient.

[REDACTED]

Diagnosis is "adjustment disorder with Anxiety. There is no Axis II Diagnosis, no premorbid vulnerabilities. [REDACTED]

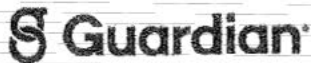
[REDACTED]

Michael F. Abramsky

Michael F. Abramsky PhD, ABPP
Licensed Clinical Psychologist
Diplomate in Clinical Psychology.
Diplomate in Forensic Psychology.

08/05/2021 17:13 T-04:00 TO: +14133955984 FROM: 2483582200

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File No. 81720
BERKSHIRE LIFE INSURANCE COMPANY OF AMERICA
 Main Office: Claims Service and Solutions Group
 PO Box 981593, El Paso, TX 79998-1593
 A wholly owned stock subsidiary of and administrator for
 The Guardian Life Insurance Company of America, New York, NY

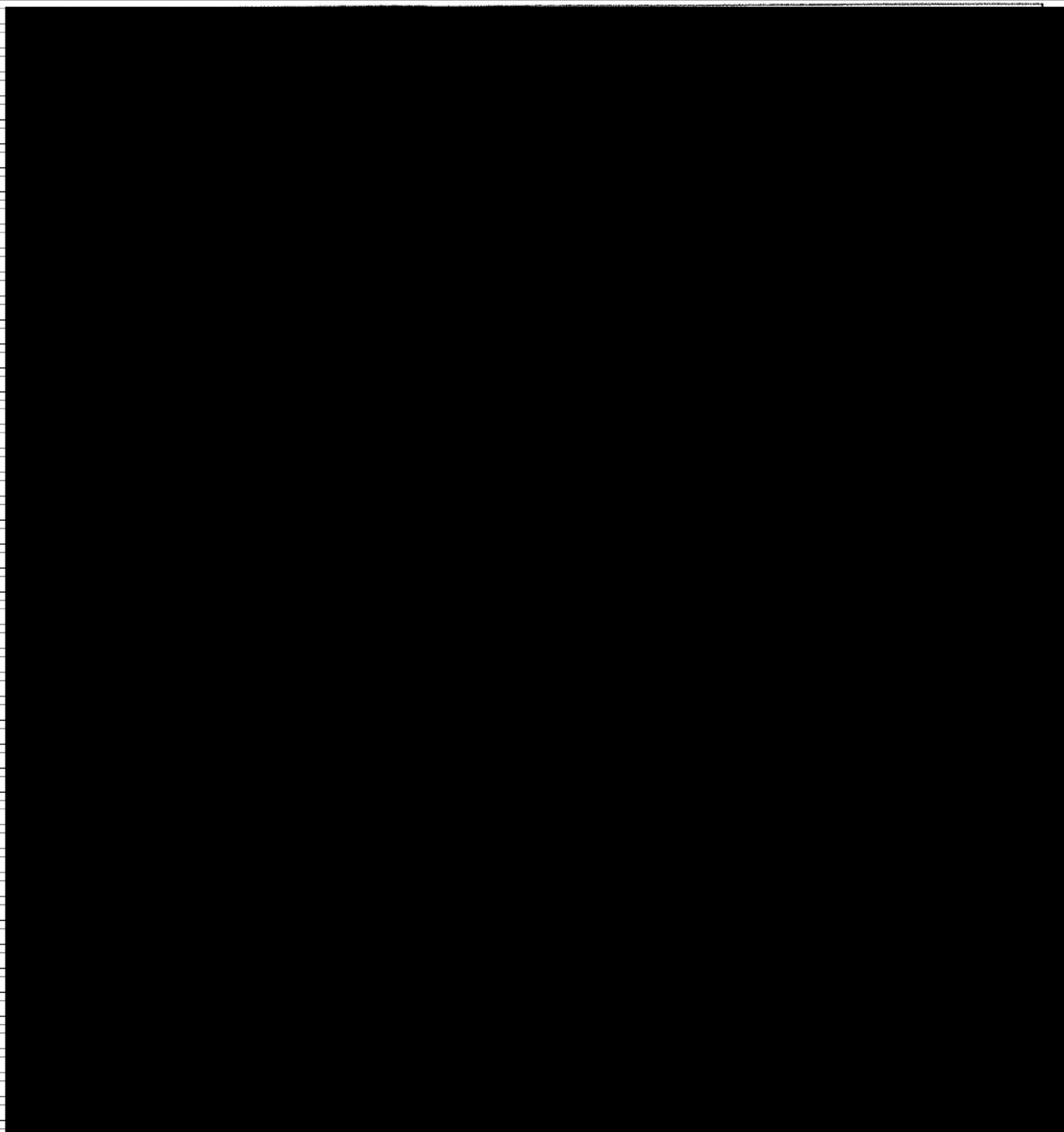
Psychiatric Physician's Statement | Questions regarding this form? Call Toll Free 1-888-275-7473

To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

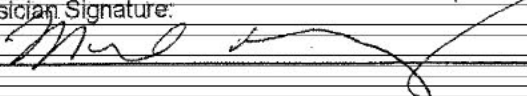
Patient's Name Ryan Fishman	File No. 81720	Date of Birth 10-24-88
Patient's Chief Complaint(s):		
Date of First Visit: 4-30-21 Date of most recent visit: 8-5-21 Date of Next Visit: 8-12-21		
Diagnosis(es): 1. 309. (DSM) Adjustment Disorder with anxiety 2. 3.		ICD-10 / DSM-V Code(s):
Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, what is your understanding of this patient's occupation(s) and job duties? Pt is a practicing attorney, administrator of a collection practice		
Are you advising this patient to:		
a) Restrict or limit work activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, as of what date? ___/___/___ If yes, what aspects of this patient's job duties are they restricted or limited from performing?		
b) Stop working altogether? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, as of what date? ___/___/___ If yes, what aspects of this patient's job duties are they unable to perform?		
What is the patient's anticipated time frame for return to work? Unknown		

08/05/2021 17:13 T-04:00 TO: +14133955984 FROM: 2483582200

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benefits.

Physician Name (please print): Michael F Ablamsky		Medical Specialty(ies): Clinical Psychology	
Office Telephone No.: 248-644-7398		Office Fax No.: none	
Office Address, City or Town, State or Province, Zip Code: 954 Cantonburg, Birmingham, AL 38009		e-mail: csmail.com	
Physician Signature: 		Date: 8-5-21	



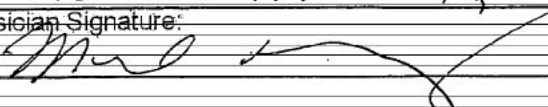
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Psychiatric Physician's Statement | Questions regarding this form? Call Toll Free 1-888-275-7473

To the Physician: Please provide answers to the questions below to support our evaluation of your patient's claim for disability benefits.

Patient's Name Ryan Fishman	File No. 81720	Date of Birth 10-24-88
Patient's Chief Complaint(s):		
Date of First Visit: 4-30-21 Date of most recent visit: 8-5-21 Date of Next Visit: 8-12-21		
Diagnosis(es): <u>309. (DSM) Adjustment Disorder with anxiety</u> ICD-10 / DSM-V Code(s): 1. _____ 2. _____ 3. _____		
Do you believe you have a sufficient understanding of this patient's occupation(s) and job duties to comment on their functional ability to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is your understanding of this patient's occupation(s) and job duties? <u>Pt is a practicing attorney, administrator of a collection practice</u> Are you advising this patient to: a) Restrict or limit work activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, as of what date? ____/____/____ If yes, what aspects of this patient's job duties are they restricted or limited from performing? b) Stop working altogether? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, as of what date? ____/____/____ If yes, what aspects of this patient's job duties are they unable to perform?		
What is the patient's anticipated time frame for return to work? <u>unknown</u>		
Does this patient have a history of a psychiatric condition? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Does this patient have a history of substance abuse? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Specify current treatment plan / type of treatment (i.e., CBT, DBT, EMDR, Medication Management, IOP, Frequency of Visits, etc.): <u>Weekly Psychotherapy, including meditation practice and general health monitoring; exercise, diet</u>		
Current medications (include dosage, frequency and last date of change):		
Treatment goals: <u>Resolve Anxiety, return to functions</u>		
Does the treatment plan include return to work goals? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Please explain:		
Is this patient compliant with your recommended treatment? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Have you discussed your treatment plan and return to work goals with this patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		

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Is this patient in agreement with the treatment plan? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Test results or other rating scale score (please specify test, scale, measure used, and date):	
No testing	
Objective observations of this patient's behaviors, affect, mood: Mood is anxious, periods of depression. Concentration, attention significantly compromised	
Subjective complaints reported by this patient (include frequency, severity, duration): Distracted, obsessive, frustrated, worried, dependent	
Is this patient treating with any other provider(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include name and specialty:	
Are you coordinating care with this provider(s)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, last date of contact:	
How would you rate this patient's current degree of psychiatric impairment?	
<input type="checkbox"/> I do not have sufficient information to make a reasonable assessment. <input type="checkbox"/> Essentially good functioning in all areas. Occupationally and socially effective. <input type="checkbox"/> Moderate impairment in occupational functioning. Limited in performing some, but not all, occupational duties. Able to maintain meaningful interpersonal relationships. <input type="checkbox"/> Major impairment in several areas, e.g., work, family relations. Avoidant behaviors, neglects family, unable to work.	
Do you believe this patient is competent to endorse checks and direct the use of the proceeds? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, as of: 8/5/21	
Do you believe this patient is competent to execute a Power of Attorney? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, as of: 8/5/21	
Have you completed disability claim forms on behalf of this patient for other insurance carriers? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please provide the name of the company(ies):	
Are you related to this patient by blood or marriage, or are you a member of this patient's household? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Are you this patient's business partner, professional partner, employer, or a person who has a financial affiliation or business interest with this patient? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Our goal is to understand the extent to which your patient is restricted or limited by the chief complaints outlined above. If we have additional questions after reviewing this form, a claim professional or clinical consultant may contact you.	
What is a convenient day and time for us to call? Tues - Friday 9-5	
What telephone number would you like us to use? 248-644-7398	
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materiality, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.	
Physician Name (please print):	Medical Specialty(ies):
Michael F Ablamsky	Clinical Psychology
Office Telephone No.:	Office Fax No.:
248-644-7398	ablamsky m f non2@gmail.com
Office Address, City or Town, State or Province, Zip Code:	
954 Canterbury, Birmingham, AL 38009	
Physician Signature:	Date:
	8-5-21